# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A.** The **State** of **Idaho** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B.** **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Children's Developmental Disabilities Waiver**

**C.** **Type of Request: new**

**Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

(•) **3 years** ( ) **5 years**

[ ] **New to replace waiver**

Replacing Waiver Number:

[ ] **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

**Base Waiver Number:**

**Amendment Number** (if applicable):

**Effective Date:** *(mm/dd/yy)*

**Waiver Number: ID.0859.R00.00**
**Draft ID: ID.07.00.00**

**D.** **Type of Waiver** *(select only one):*

Regular Waiver

**E.** **Proposed Effective Date:** *(mm/dd/yy)*

07/01/11

**Approved Effective Date: 07/01/11**

### 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☑ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☐ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Idaho offers waiver services to eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration.

The purpose of the Children's DD waiver is to support children and youth, ages 0 - 17, to remain in their family home and in the community. The Bureau of Developmental Disability Services (BDDS) envisions a program that offers a continuum of care that meets every child's needs. To accomplish this the program's key elements include an array of therapeutic interventions, support services, and family training and education.

The primary objective of the Children's DD program is to incorporate family involvement into all aspects of their child's services and to achieve lasting positive outcomes. To accomplish this families will partner with professionals in order to design and implement interventions that will work best for them and their child. Upon a child's enrollment on the waiver, the Department will educate families on the array of services available to them and will set the family up with a Targeted Case Manager (TCM).

The TCM's role will be to assess the child and family's needs through a family-centered planning process. This process will assist the TCM to develop an Action Plan based on the family's wants and skill level. The Action Plan will list prioritized services and objectives according to the family's goals. Once the program is implemented, the TCM will be responsible for tracking progress and ensuring the child is receiving appropriate services with positive outcomes.

With regard to the organizational structure, the State of Idaho's Children's DD waiver is managed by the Bureau of Developmental Disability Services (BDDS), within the Idaho Department of Health and Welfare, Division of Medicaid. All aspects of the Waiver are directly managed by the state.

The service delivery methods are as follows: Eligibility determinations are completed by an Independent Assessment Provider (IAP) contracted with the Department. When a child is determined eligible for waiver services they are referred to a Targeted Case Manager (TCM) contracted with the Department. The TCM completes the family-centered planning process and is responsible for coordinating services for the family. Service providers that offer direct services are subject to the terms of a provider agreement specific to their provider type and specialty.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation

and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:
Idaho has well-established provider, advocate, and participant associations that provide frequent feedback to the Department regarding our programs for people with developmental disabilities.

For the past two years the Department has been meeting with a variety of stakeholder groups to receive input on how to restructure the current children's DD program in an effort to improve services for children with DD in Idaho. This project is referred to as the Children's System Redesign and includes families, schools, providers, advocates and other divisions within the Department to ensure all perspectives of a child's system of care are considered. The Children's Redesign committees continue to be included during the development of the new benefits. In addition to these ongoing meetings, the Department has also developed a website where updates are posted and feedback can be received by all regarding the Redesign Project.

In addition, administration and oversight of the waiver program is governed by Idaho Administrative Code. The Department typically engages in negotiated rulemaking to develop proposed changes to administrative rules. Prior to final implementation of any proposed changes to administrative rules, the proposed rules must be published in the Idaho Administrative Bulletin, the public is given an opportunity to comment on the proposed rules, and the Idaho Legislature must review and approve the proposed changes.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

| | |
|---|---|
| **Last Name:** | Simnitt |
| **First Name:** | David |
| **Title:** | Program Manager |
| **Agency:** | Idaho Division of Medicaid |
| **Address:** | P.O. Box 83720 |
| **Address 2:** | |
| **City:** | Boise |
| **State:** | **Idaho** |
| **Zip:** | 83720 |
| **Phone:** | (208) 364-1992 **Ext:** ☐ **TTY** |
| **Fax:** | (208) 332-7286 |

**E-mail:** SimnittD@dhw.idaho.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Idaho**

**Zip:**

**Phone:** **Ext:** **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:** Paige Grooms

State Medicaid Director or Designee

**Submission Date:** Sep 10, 2010

**Last Name:** Clement

**First Name:** Leslie

**Title:** Administrator

**Agency:** Idaho Division of Medicaid

**Address:** P.O. Box 83720

**Address 2:**

**City:** Boise

**State:** **Idaho**

**Zip:** 83720

**Phone:** (208) 334-5747

**Fax:** (208) 364-1181

**E-mail:** ClementL@dhw.idaho.gov

## Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - **The Medical Assistance Unit.**

       Specify the unit name:
       **Bureau of Developmental Disabilities Services**
       *(Do not complete item A-2)*

     - **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

       Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

       *(Complete item A-2-a).*

   - **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the division/unit name:

     In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   **As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   The Department contracts with an Independent Assessment Provider (IAP) to complete level of care determinations and assign individualized budgets.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Department of Health and Welfare oversees the contract with the Independent Assessment Provider (IAP).

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
IAP contract monitoring: Contract monitoring reviews the performance of the Independent Assessment Provider (IAP).

Quarterly data and review: Data is collected that reflects the contractor's performance according to the defined business model timeframes. When performance measures are not met, or there are changes in performance expectations, program managers from the Department and the contracted entity discuss the issues and identify changes as needed to resolve issues. The Department has ongoing access and reviews this data on a monthly basis.

Quarterly contract monitoring reports: This report looks at each performance metric and provides information in relation to compliance, it evaluates timeframe compliance and level of care eligibility accuracy according to the BDDS business model, and it also looks at staff training provided during the quarter. Any complaints and resolutions that come up are tracked on an ongoing basis. If the performance was not satisfactory, follow-up is completed by the Department contract monitor to develop a plan of correction specific to the problem area.

Outcome-Based Review: The intent of the outcome-based review is to ensure that the components of the business model are implemented consistently across the state and participants are receiving services to meet their needs. This review is a quality improvement strategy focused on collecting information directly from the participant and their caregivers, as well as reviewing contractor files to ensure accuracy of records.

Collecting information from participants and caregivers validates that participants are correctly determined eligible for waiver programs, participant and guardian satisfaction with services, services continue to be clinically necessary, services accurately reflect the assessed need of the participant, identified services constitute appropriate care and warrant continued authorization, statewide consistent service delivery, statewide consistent process delivery, and compliance with the regulations governing the children's DD waiver program.

The contractor's record review looks at files to validate that documents are tracked and accessible; necessary signatures are obtained; documents are processed within business model timeframes; accurate documentation related

to participant's diagnosis, medical history and medical or behavioral needs are recorded; level of care eligibility is correctly determined according to the Idaho standard; the plan continues to accurately reflect the assessed needs of the participant; and demographic information is correctly recorded.

Outcome-Based Reviews are completed at least every two years. The information received through these review processes validate the performance of the contractor in relation to clinical decision making. This information is provided to the contractor and a plan of correction must be developed for those areas not meeting contract performance standards.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| **Participant waiver enrollment** | ☑ | ☑ |
| **Waiver enrollment managed against approved limits** | ☑ | ☐ |
| **Waiver expenditures managed against approved levels** | ☑ | ☐ |
| **Level of care evaluation** | ☑ | ☑ |
| **Review of Participant service plans** | ☑ | ☐ |
| **Prior authorization of waiver services** | ☑ | ☐ |
| **Utilization management** | ☑ | ☐ |
| **Qualified provider enrollment** | ☑ | ☐ |
| **Execution of Medicaid provider agreements** | ☑ | ☐ |
| **Establishment of a statewide rate methodology** | ☑ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☐ |
| **Quality assurance and quality improvement activities** | ☑ | ☐ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be*

*specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of deficiencies corrected by contractor as identified by contract monitor.**

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>IAP contractor | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** | ☐ **Annually** |

| | |
|---|---|
| Specify: | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department monitors contractors for timeliness and accuracy of DD and waiver eligibility determinations through a combination of concurrent, retrospective reviews; reconsideration of decision data; and quality assurance data provided quarterly to the Department's IAP contract monitor.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Non-compliance will result in the contractor developing and submitting a plan of correction for Department approval. Continued non-compliance may result in termination of the contract.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

# Appendix B: Participant Access and Eligibility

## B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ○ Aged or Disabled, or Both - General | | | | | |
| | ☐ | Aged | | | ☐ |
| | ☐ | Disabled (Physical) | | | |
| | ☐ | Disabled (Other) | | | |
| ○ Aged or Disabled, or Both - Specific Recognized Subgroups | | | | | |
| | ☐ | Brain Injury | | | ☐ |
| | ☐ | HIV/AIDS | | | ☐ |
| | ☐ | Medically Fragile | | | ☐ |
| | ☐ | Technology Dependent | | | ☐ |
| ◉ Mental Retardation or Developmental Disability, or Both | | | | | |
| | ☑ | Autism | 0 | 17 | ☐ |
| | ☑ | Developmental Disability | 0 | 17 | ☐ |
| | ☑ | Mental Retardation | 0 | 17 | ☐ |
| ○ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

Within 6-9 months of the participant's 18th birthday, participants who want to apply for Adult DD Waiver services can apply through the Bureau of Developmental Disability Services located in their local Medicaid office. However, Adult DD Waiver services cannot begin before the participant’s 18th birthday.

The Targeted Case Manager (TCM) completes all duties identified on the Care Manager Adult Intake Checklist, and then forwards the Eligibility Application for Adults with DD and any other intake documents to the Adult program's IAP.

For applications received within 6 to 9 months of a participant turning 18, the IAP can begin the assessment process and determine Adult DD Waiver eligibility prior to the participant's 18th birthday. Documentation of the participant's developmental disability prior to age 22 should be made available to the IAP. This includes previous psychological and/or medical records.

The IAP will review the application and schedule an intake appointment with the participant to complete the DD and ICF/MR Level of Care (LOC) eligibility process. The participant must come to the intake appointment with their parent/legal guardian. The parent/legal guardian will serve as the respondent for the Scales of Independent Behavior—Revised (SIBR).

The participant will receive Notices from the IAP indicating whether their Adult DD Waiver eligibility has been approved or denied. A copy of the eligibility determination, and available assessments will be shared with the TCM.

If the participant is not determined Adult DD Waiver eligible, the Notice will inform the participant of their right to ask for a reconsideration of the decision. The TCM will assist the participant in accessing other available services and resources to meet their needs.

If the participant is determined Adult DD Waiver eligible, the Notice will tell the participant their calculated individualized budget and will provide them with the option to choose either the Traditional Option or the Self-Directed Option. The participant's current TCM will identify tasks associated with transitioning the participant into the Adult DD Program. Children's TCM services will end effective the start date identified on the participant's approved and prior authorized adult plan.

If the participant chooses the Self-Direction Option, they will need to contact the Bureau of Developmental Disability Services to follow the processes associated with that choice.

If the participant chooses the Traditional Option, they will decide which Service Coordination agency they would like to provide Plan Development. The participant must notify the IAP of their choice. NOTE: Plan Development can be approved but cannot be prior authorized until the participant has turned 18. The Plan Developer must submit a written request to the Department for Plan Development hours. This request will be reviewed and approved by the assigned Care Manager. The development of an Adult DD service plan will help guide service provision to the participant through the next year.

# Appendix B: Participant Access and Eligibility

## B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

**The limit specified by the State is** *(select one)*

- ( ) **A level higher than 100% of the institutional average.**

  Specify the percentage: [ ]

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is** *(select one)*:

**The following dollar amount:**

Specify dollar amount:

**The dollar amount** *(select one)*

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 2100 |
| **Year 2** | 2226 |
| **Year 3** | 2360 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| Year 1 | |
| Year 2 | |
| Year 3 | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

# Appendix B: Participant Access and Eligibility

## B-4: Eligibility Groups Served in the Waiver

**a.**

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  *Select one*:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☑ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  *Specify:*

***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

- **A special income level equal to:**

  *Select one*:

  - **300% of the SSI Federal Benefit Rate (FBR)**
  - **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage:
  - **A dollar amount which is lower than 300%.**

    Specify dollar amount:
- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  *Select one*:

  - **100% of FPL**
  - **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- (●) **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - (●) **Use spousal post-eligibility rules under §1924 of the Act.**
    *(Complete Item B-5-b (SSI State) and Item B-5-d)*
  - ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    *(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)*
- ( ) **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  *(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

- ( ) **The following standard included under the State plan**

  *Select one*:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the State Plan**

*Specify:*

**The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

**The following formula is used to determine the needs allowance:**

*Specify:*

300% of the SSI Federal Benefit Rate plus the following personal needs allowances if there is enough income.
Persons with earned income. The personal needs allowance is increased by $200 or the amount of their earned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

Persons with a court-ordered guardian. The personal needs allowance is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or $25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed $25. The individual needs a greater personal needs allowance to offset their guardian fees.

Persons with a trust. The personal needs allowance is increased by trust fees, not to exceed $25 paid to the trustee for administering the individual's trust. These individuals need a greater personal needs allowance to offset their trust fees.

Blind or disabled employed persons with impairment-related work expenses. Impairment-related work expenses are purchased or rented items and services purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. These individuals need a greater personal needs allowance to offset their impairment-related work expenses.

**Other**

*Specify:*

**ii. Allowance for the spouse only** (*select one*):

**Not Applicable**

**The state provides an allowance for a spouse who does not meet the definition of a community**

**spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

**Specify the amount of the allowance** (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  *Specify:*

**iii. Allowance for the family** (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  *Specify:*
- **Other**

  *Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 4)

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

Specify percentage:

- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

*Specify formula:*

300% of the SSI Federal Benefit Rate plus the following personal needs allowances if there is enough income.

Persons with earned income. The personal needs allowance is increased by $200 or the amount of their earned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

Persons with a court-ordered guardian. The personal needs allowance is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or $25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed $25. The individual needs a greater personal needs allowance to offset their guardian fees.

Persons with a Trust. The personal needs allowance is increased by trust fees, not to exceed $25 paid to trustee for administering the individual's trust. These individuals need a greater personal needs allowance to offset their trust fees.

Blind or disabled employed persons with impairment -related work expenses. Impairment-related work expenses are purchased or rented items and services purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. These individuals need a greater personal needs allowance to offset their impairment-related work expenses.

- **Other**

*Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- **Allowance is the same**
- **Allowance is different.**

*Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

**ii. Frequency of services.** The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

The Independent Assessment Provider (IAP)

- ( ) **Other**

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualified Mental Retardation Professional (QMRP).
A QMRP has at least one (1) year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is licensed as a doctor of medicine or osteopathy, or as a registered nurse, or has at least a bachelor's degree in one (1) of the following professional categories; psychology, social work, occupational therapy, speech pathology, audiology, professional recreation, or a related human services profession.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All participants must meet ICF/MR Level of Care. ICF/MR LOC is defined in Idaho Administrative Rule at IDAPA 16.03.10.584 and requires that the participant have a developmental disability as defined in Section 66-402, Idaho Code and in Sections 500 through 503 of IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." In addition, the participant must qualify based on functional assessment, maladaptive behavior, a combination of both, or a medical condition. The Scales of Independent Behavior - Revised (SIB-R) is used to evaluate functional limitations and maladaptive behavior.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Independent Assessment Provider (IAP) collects evaluations and other information relevant to the participant's developmental disability. Typically, these evaluations include IQ testing or medical assessments/diagnoses to document that the participant meets categorical impairment criteria outlined in Section 66-402, Idaho Code. In addition, the IAP conducts the SIB-R assessment and completes the Medical/Social and Developmental History to make a final eligibility determination for developmental disability services as outlined in Sections 500 through 503 of IDAPA 16.03.10 and ICF/MR Level of Care (LOC) criteria as outlined in Section 584 of IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

All LOC decisions are forwarded to the Targeted Case Management Provider electronically, as well as maintained in participant files at the IAP offices. Participants receive written notification regarding their LOC determinations. Participants who are found to not meet LOC criteria are informed of their right to request a reconsideration of decision. Reconsideration requests are sent to and conducted by the Department.

The annual reevaluation is the same except the IAP may not always conduct a new SIB-R if the clinical review indicates the previous assessment is still reflective of the participant's current condition. The annual clinical review includes a review of the participant's current status, evaluation for substantial change, and a face-to-face meeting with the participant to update the Medical/Social and Developmental History.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**
  *Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  *Specify the qualifications:*

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The Independent Assessment Provider (IAP) utilizes an electronic database to track annual redetermination dates and ensure timely reevaluations. The Department ensures the IAP continues to meet contract requirements through monitoring of quarterly IAP reports and annual statewide reviews.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The IAP maintains these records at their regional hub offices.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
   i. **Sub-Assurances:**
      a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants whose DD and ICF/MR level of care eligibility is determined within 30 days of receipt of a complete application packet.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:
**Contract monitoring**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☑ **Other** Specify: IAP Contract | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of waiver participants who received an annual redetermination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation.**

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>IAP contractor | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

| | | |
|---|---|---|
| | | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants reviewed who were identified to meet program eligibility criteria.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100%** |

| | | |
|---|---|---|
| | | **Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>IAP Contractor | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of ICF/MR level of care assessments reviewed that were completed by qualified staff.**

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>IAP contractor | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department monitors the IAP contractor for timeliness and accuracy of DD and waiver eligibility determinations through a combination of concurrent, retrospective reviews; reconsideration of decision data; and quality assurance data provided quarterly to the Department's IAP contract monitor.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Department ensures positive participant outcomes and quality of care through participant outcome reviews and data analysis. Through these two data collection processes, individual problems are discovered and remediated.
Participant outcome reviews involve the utilization of the Participant Experience Survey (PES). The first two steps include collecting demographic and medical/social history from the participant's file and administering the PES by surveying the participant and family in person. If areas of concern are identified during this initial review, an enhanced review is conducted for further investigation. This involves interviews with the participant, close family or friends, and the service provider.
If a service deficiency is found during an Enhanced review, a Plan of Correction (POC) is initiated. The POC must include a response to each deficiency stating:
- What actions will be taken,
- Who will be responsible for the corrective action,

- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

If the review reveals issues that potentially put the participant's health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database. The Department also follows an enforcement and remedies process when discovering that a Developmental Disabilities Agency (DDA) has not met rule or finds that the DDA's deficiencies immediately jeopardize the health and safety of its participants. The process under IDAPA rule for "Developmental Disabilities Agencies" is as follows:

300. ENFORCEMENT PROCESS.
01. Recommendation of Remedy. In determining which remedy or remedies to recommend, the Department will consider the DDA's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, the integrity of the program, and the potential risk to participants. Subject to these considerations, the Department may impose, as warranted, any of the remedies described in Subsection 300.02 of this
rule.
02. Enforcement Remedies. If the Department finds that a DDA has not met a rule governing developmental disabilities agencies, it may impose any of the following remedies in accordance with Subsection 300.01 of this rule, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal:
a. Require the DDA to complete a plan of correction;
b. Issue a provisional certificate with a specific date for correcting deficient practices;
c. Ban enrollment of all participants with specified diagnoses;
d. Ban any new enrollment of participants;
e. Revoke the DDA's certificate; or
f. Summarily suspend the certificate and transfer participants.
03. Immediate Jeopardy. If the Department finds that the DDA's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may summarily suspend the DDA's
certificate.
04. No Immediate Jeopardy. If the Department finds that the DDA's deficiency or deficiencies do not immediately jeopardize participant health or safety, the Department may impose one (1) or more of the remedies specified in Subsections 300.02.a. through 300.02.e. of this rule.
05. Repeat Deficiencies. If the Department finds a repeat deficiency in a DDA, it may impose any of the remedies listed in Subsection 300.02 of this rule, as warranted. The Department may monitor the DDA on an "as needed" basis, until the DDA has demonstrated to the Department's satisfaction that it is in compliance with these rules. If so, then certification will be granted. If not, the certificate will be denied or revoked.
06. Failure to Comply. The Department may impose one (1) or more of the remedies specified in Subsection 300.02 of this rule if:
a. The DDA has not complied with any requirement in these rules within three (3) months after the date it was notified of its failure to comply with such requirement; or
b. The DDA has failed to correct the deficiencies stated in the DDA's accepted plan of correction and as verified by the Department, via review, or resurvey, or both.

System Data Review involves obtaining data for indicators not specific to the participant outcome review, including provider requirements and contract monitoring. The data for these indicators are collected through quarterly, annual, biennial reports and reviews.

Regarding contractor performance, non-compliance will result in the contractor developing and submitting a plan of correction for Department approval. Continued non-compliance may result in termination of the contract.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of waiver application, the the IAP provides participants with information about waiver services. When a participant is determined eligible for waiver services, the the Targeted Case Manager provides additional information about available services. Eligible participants and their family-centered planning teams select the specific waiver services they wish to receive by including these services on the Action Plan. In addition, this plan includes a statement that the participant chooses to receive waiver services in the community rather than services in an ICF/MR.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Action Plan which documents freedom of choice is maintained in the following locations:

The Independent Assessment Provider’s office.
The Targeted Case Manager's office.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Department makes many of its publications available in both English and Spanish. These publications are displayed and distributed in the regional offices throughout the state. An example of one of these publications, the "Idaho Health Plan Coverage" booklet, is also available online. It provides an overview of Medicaid services in Idaho including waiver services. It can be accessed at http://healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx.

In addition, the State of Idaho website has been translated into Spanish at http://idaho.gov/espanol.html and has a link to the Department of Health & Welfare website in Spanish. The main Department of Health and Welfare website at www.healthandwelfare.idaho.gov also provides a link to a Spanish version by clicking the "Espanol" button at the bottom of the page. Individuals who have additional questions are directed on these websites to contact the widely-publizied Idaho Care Line by dialing 2-1-1.

The Department's Division of Human Resources maintains a list of Department staff available for translation assistance for various languages. This is on our Infonet and is divided by region. It also lists outside people who have made themselves available.

Information on using Language Line Services is also included. The Department has a contract with this entity to provide translation for various languages via the telephone.

Translation services are provided free of charge.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service |
|---|---|
| **Extended State Plan Service** | **Habilitative Supports** |
| **Extended State Plan Service** | **Respite** |
| **Supports for Participant Direction** | **Community Support Services** |
| **Supports for Participant Direction** | **Financial Management Services** |
| **Supports for Participant Direction** | **Support Broker Services** |
| **Other Service** | **Crisis Intervention** |
| **Other Service** | **Family/Interdisciplinary Training** |
| **Other Service** | **Habilitative Intervention** |
| **Other Service** | **Therapeutic Consultation** |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Habilitative Supports

**Service Definition** *(Scope):*

Habilitative Supports provides assistance to a participant with a disability by facilitating their independence and integration into the community. This service provides an opportunity for a participant to explore their interests

and improve their skills by participating in natural environments.

Habilitative Supports is not active treatment. Instead, the participant learns through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities.

This service is only provided in the participant's home or in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or therapy, nor are they intended to supplant the primary caregiver.

The supports provider must maintain a log of the habilitative support services in the participant's record documenting the provision of activities outlined in the Action Plan. Supports that take place in both the home and community must ensure the participant is actively participating in age appropriate activities and is engaging with typical peers.

Limitations:
- Habilitative Supports must be necessary to ensure the participant's safety if he or she cannot be left unsupervised due to health and safety concerns or cannot be cared for in the community in a normalized child care center due to the severity of their diagnosis.

- Habilitative Supports cannot be provided during the same time other waiver services are being provided to a participant.

- Habilitative Supports shall not duplicate other Medicaid reimbursed services which include but are not limited to: Respite, Psychosocial Rehabilitation and Partial Care.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Services are provided when the limits of Habilitative Supports under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from habilitative support services furnished under the State plan. The additional amount of services that may be provided through the waiver is as follows:
- Subject to the participant's individualized budget.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Developmental Disabilities Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Habilitative Supports**

**Provider Category:**
Agency
**Provider Type:**
Developmental Disabilities Agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*
Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide habilitative supports in a DDA:

Must be at least 18 years of age; must be a high school graduate or have a GED; demonstrate the ability to provide services according to a plan of service; have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; be willing to accept training and supervision; be free of communicable diseases; demonstrate knowledge of infection control methods; agree to practice confidentiality in handling situations that involve participants; pass a criminal background check; and complete a competency course approved by the Department related to the support staff job requirements.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Department of Health and Welfare

**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Extended State Plan Service

**Service Title:**
Respite

**Service Definition** *(Scope):*
Respite is provided to the participant on an intermittent or short-term basis because of the absence or need for relief of the primary unpaid caregiver. Respite services are provided in a variety of settings and may be provided on an hourly or daily basis.

Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a developmental disabilities agency, or in community settings.

Respite may only be offered to participants who have an unpaid primary caregiver living in the home who requires relief.

Limitations:
•Payment for respite services are not made for room and board.
•Respite cannot be provided during the same time other waiver services are being provided to a participant.
•Respite cannot be provided on a continuous, long-term basis where it is part of daily services that would enable an unpaid caregiver to work.
•Respite services shall not duplicate other Medicaid reimbursed services which include but are not limited to: Habilitative Supports, Psychosocial Rehabilitation and Partial Care.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
•Services are provided when the limits of Respite under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from Respite services furnished under the State plan. The

additional amount of services that may be provided through the waiver is as follows:
- Subject to the participant's individualized budget.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Developmental Disabilities Agency |
| Individual | Respite Care Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Respite**

**Provider Category:**
Agency
**Provider Type:**
Developmental Disabilities Agency
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.
**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite in a DDA:

Providers must meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family, or the participant's guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; be willing to accept training and supervision; be free of communicable diseases; and pass a criminal background check.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Department of Health and Welfare
**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Respite**

**Provider Category:**
Individual
**Provider Type:**
Respite Care Provider
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite:

Providers must meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family, or the participant's guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; be willing to accept training and supervision; be free of communicable diseases; and pass a criminal background check.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Department of Health and Welfare
**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
**Support for Participant Direction:**
Other Supports for Participant Direction
**Alternate Service Title (if any):**
Community Support Services
**Service Definition** *(Scope):*
Community Support Services provide goods and supports that are medically necessary and/or minimize the participant's need for institutionalization and address the participant's preferences for:

- Personal support to help the participant maintain health, safety, and basic quality of life.

- Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, or others in order to build a natural support network and community.

- Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors.

- Adaptive support to help a child to learn new adaptive skills or expand their existing skills.

- Transportation support to help the participant accomplish their identified goals.

- Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes their increased independence.

- Skilled Nursing.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Only participants who select the Family-Directed Option may access this service. There are no limits on the amount, frequency, or duration of these services other than participants must stay within their prospective individual budget amount.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Community Support Agency |
| Individual | Community Support Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Supports for Participant Direction**
**Service Name: Community Support Services**

**Provider Category:**
Agency
**Provider Type:**
Community Support Agency
**Provider Qualifications**
**License** *(specify):*
If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.
**Certificate** *(specify):*
If required to identify goods or supports.
**Other Standard** *(specify):*
Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Participant and parent/legal guardian
Paid Support Broker (if applicable)
Department of Health and Welfare (during retrospective quality assurance reviews)

**Frequency of Verification:**
Initially and annually, with review of employment/vendor agreement

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Supports for Participant Direction**
**Service Name: Community Support Services**

**Provider Category:**
Individual
**Provider Type:**
Community Support Provider
**Provider Qualifications**
**License** *(specify):*
If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.
**Certificate** *(specify):*
If required for identified goods and supports.
**Other Standard** *(specify):*
Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Participant and parent/legal guardian
Paid Support Broker (if applicable)
Department of Health and Welfare (during retrospective quality assurance reviews)
**Frequency of Verification:**
Initially and annually, with review of employment/vendor agreement

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
**Support for Participant Direction:**
Financial Management Services
**Alternate Service Title (if any):**
Financial Management Services
**Service Definition** *(Scope):*
The Department will offer financial management services through any qualified fiscal employer agent (FEA) provider through a provider agreement.

FEA providers will complete financial consultation and services for a participant who has chosen to family-direct their services in order to assure that the financial information and budgeting information is accurate and available to them as is necessary in order for successful family-direction to occur.

A. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the family-directed community supports option;

B. Financial Reporting. Performing financial reporting for employees of each participant;
C. Financial Information Packet. Preparing and distributing a packet of information, including department approved forms for agreements, for the participant and family hiring their own staff;
D. Time Sheets and Invoices. Processing and paying timesheets for community support workers and support brokers, as authorized by the participant and family according to the participant's Department authorized support and spending plan;
E. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker;
F. Payments for goods and services. Processing and paying invoices for goods and services, as authorized by the participant and family, according to the participant's support and spending plan;
G. Spending information. Providing each participant and family with reporting information and data that will assist the participant with managing the individual budget;
H. Quality assurance and improvement. Participation in department quality assurance activities.

FEA providers complete financial services and financial consultation for participants and their parent/legal guardian that is related to a family-directed participant's individual budget. The FEA assures that the financial data related to the participant's budget is accurate and available to them and their parent/legal guardian as necessary in order for successful family-direction to occur. FEA qualifications and requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Only participants who select the family-directed option may access this service.

The FEA must not either provide any other direct services (including support brokerage) to the participant to ensure there is no conflict of interest; or employ the parent/legal guardian of the participant or have direct control over the participant's choice.

The FEA providers may only provide financial consultation, financial information and financial data to the participant and their parent/legal guardian, and may not provide counseling or information to the participant and parent/legal guardian about other goods and services.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Fiscal Employer/Agent |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Supports for Participant Direction**
**Service Name: Financial Management Services**

**Provider Category:**
Individual
**Provider Type:**
Fiscal Employer/Agent
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Agencies that provide financial management services as a FEA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Department of Health and Welfare

**Frequency of Verification:**
At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**
Information and Assistance in Support of Participant Direction

**Alternate Service Title (if any):**
Support Broker Services

**Service Definition** *(Scope):*
Support brokers provide counseling and assistance for participants and families with arranging, directing, and managing services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants and families with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable families to remain independent. Examples of skills training include helping families understand the responsibilities involved with directing services, providing information on recruiting and hiring community support workers, managing workers and providing information on effective communication and problem-solving. The extent of support broker services furnished to the participant must be specified on the support and spending plan.

Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant and family's needs and preferences. At a minimum, the paid support broker (when chosen) must:

- Participate in the person centered planning process.

- Develop a written support and spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three backup plans should a support fall out.

- Assist the participant and family to monitor and review their budget through data and financial information provided by the FEA.

- Submit documentation regarding the participant and family's satisfaction with identified supports as requested by the Department.

- Participate with Department quality assurance measures, as requested.

- Assist the participant and family with scheduling required assessments to complete the Department's annual re-determination process as needed, including assisting the participant and family to update the support and spending plan and submit it to the Department for authorization.

In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant and family:

- Assist the participant and family to develop and maintain a circle of support.

- Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports.

- Assist the participant and family to negotiate rates for paid Community Support Workers.

- Maintain documentation of supports provided by each Community Support Worker and participant's satisfaction with these supports.

- Assist the participant and family to monitor community supports.

- Assist the participant and family to resolve employment-related problems.

- Assist the participant and family to identify and develop community resources to meet specific needs.

Support Brokers provide counseling and assistance for families by arranging, directing and managing services. This includes providing families with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Support Broker qualifications, requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Only participants who select the Family-Directed Option may access this service.

Support brokers may not act as a fiscal employer agent, instead support brokers work together with the participant and family to review participant financial information that is produced and maintained by the fiscal employer agent.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Support Broker |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Supports for Participant Direction**
**Service Name: Support Broker Services**

**Provider Category:**

Individual

**Provider Type:**
Support Broker
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Specific requirements outlined in Idaho Administrative Code - IDAPA 16.03.13 include review of education, experience, successful completion of Support Broker training and ongoing education.

The parent/legal guardian can be an unpaid support broker for the participant and are subject to the same qualification requirements as paid support brokers.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Participant and Parent/legal guardian
Department of Health and Welfare
**Frequency of Verification:**
At the time of application, annual review of ongoing education requirement, and by participant when entering into employment agreement.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Crisis Intervention
**Service Definition** *(Scope):*
Crisis Intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis.

Children's crisis intervention services are intensive and provided in the home or other placement authorized by the Department. The intent of this service is to bring a team of professionals into the family's home in order to maintain the child in a least restrictive environment while alleviating the crisis situation.

Crisis intervention services will not duplicate other Medicaid reimbursed services (including services under this waiver).
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Prior authorization is required.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Crisis Intervention Provider |
| Agency | Developmental Disabilities Agency Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Crisis Intervention**

**Provider Category:**

Individual

**Provider Type:**

Crisis Intervention Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide crisis intervention:

Doctoral or Master's degree in psychology, education, or related discipline with 1500 hours of relevant coursework and/or training in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, and/or behavior analysis (may be included as part of degree program); Two years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.

This service also provides for emergency technician services for direct support of a recipient in crisis in addition to the primary care giver. Emergency intervention technician must meet the minumum provider qualifications under Habilitative Support services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Health and Welfare

**Frequency of Verification:**

- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Crisis Intervention**

**Provider Category:**

Agency

**Provider Type:**
Developmental Disabilities Agency Provider
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
- Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.
**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide crisis intervention in a DDA:

- Doctoral or Master's degree in psychology, education, or related discipline with 1500 hours of relevant coursework and/or training in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, and/or behavior analysis (may be included as part of degree program); Two years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.

- This service also provides for emergency technician services for direct support of a recipient in crisis in addition to the primary care giver. Emergency intervention technician must meet the minimum provider qualifications under Habilitative Support services.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Department of Health and Welfare
**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Family/Interdisciplinary Training
**Service Definition** *(Scope):*
Family/interdisciplinary training is professional assistance to families or direct service providers to help them better meet the needs of the waiver participant receiving intervention services.

Training is provided to families and direct staff to meet the specific needs of the waiver participant as outlined in the Action Plan, and may include:
• Health and Medication Monitoring
• Positioning and transfer
• Basic and advanced instructional techniques
• Positive Behavior Support
• Use of equipment

Family/Interdisciplinary training must be provided to the participant's parent or legal guardian, or the direct service provider when the participant is present.

Limitations:
Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service.
Interdisciplinary training between employees of the same discipline is not a reimburseable service.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Families are required to participate in family training when the participant is receiving habilitative interventions. The frequency must be determined by the interdisciplinary team and the family.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Developmental Disabilities Agency Provider |
| Individual | Family/Interdisciplinary Training Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family/Interdisciplinary Training**

**Provider Category:**
Agency
**Provider Type:**
Developmental Disabilities Agency Provider
**Provider Qualifications**
**License** *(specify):*
The following professionals can provide family/interdisciplinary training in a DDA:
- Occupational Therapist
- Physical Therapist
- Speech-Language Pathologist
- Advanced Registered Nurse Practitioner
- Physician Assistant
- Psychiatrist

**Certificate** *(specify):*
Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.
**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide family/interdisciplinary training in a DDA:

- Habilitative Interventionist
- Therapeutic Consultant

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Department of Health and Welfare
**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family/Interdisciplinary Training**

**Provider Category:**
Individual

**Provider Type:**
Family/Interdisciplinary Training Provider

**Provider Qualifications**

**License** *(specify):*
- Occupational Therapist
- Physical Therapist
- Speech-Language Pathologist
- Advanced Registered Nurse Practitioner
- Physician Assistant
- Psychiatrist

**Certificate** *(specify):*

**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide family/interdisciplinary training in a DDA:
- Therapeutic Consultant

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Department of Health and Welfare

**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Habilitative Intervention

**Service Definition** *(Scope):*
Habilitative Intervention services are provided to improve a child's competencies and discourage problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative Interventions must place emphasis on the development of desirable adaptive behaviors rather than merely the elimination or suppression of undesirable behavior.

Habilitative Intervention services will be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as

treatments for specific problems.
Habilitative Intervention must be provided in the participant's home and community setting, and in addition may be provided in a center-based setting.

Habilitative intervention services will not duplicate other Medicaid reimbursed services (including services under this waiver).
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Subject to the participant's individualized budget.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Developmental Disabilities Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Habilitative Intervention**

**Provider Category:**
Agency
**Provider Type:**
Developmental Disabilities Agency
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*
Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.
**Other Standard** *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide habilitative intervention in a DDA:

Must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college;
b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities;
c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; and
d. Must complete a supervised practicum

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Department of Health and Welfare
**Frequency of Verification:**
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Therapeutic Consultation

**Service Definition** *(Scope):*

Therapeutic Consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more sophisticated level of training and assistance.

Therapeutic Consultation services include advanced assessments, developing and overseeing the implementation of a positive behavior support plan, monitoring the progress and coordinating the implementation of the plan across environments including providing consultation to other service providers.

Limitations:

•Therapeutic Consultation is a short-term service and is not intended to be used as the primary direct intervention.

•Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

- Therapeutic Consultation is limited to 12 hours per year.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Developmental Disabilities Agency Provider |
| Individual | Therapeutic Consultant |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Therapeutic Consultation**

**Provider Category:**

Agency

**Provider Type:**

Developmental Disabilities Agency Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

- Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

**Other Standard** *(specify):*

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide therapeutic consultation in a DDA:

Doctoral or Master's degree in psychology, education, or related discipline with 1500 hours of relevant coursework and/or training in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, and/or behavior analysis (may be included as part of degree program); Two years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Health and Welfare

**Frequency of Verification:**

- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Therapeutic Consultation**

**Provider Category:**

Individual

**Provider Type:**

Therapeutic Consultant

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide therapeutic consultation:

Doctoral or Master's degree in psychology, education, or related discipline with 1500 hours of relevant coursework and/or training in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, and/or behavior analysis (may be included as part of degree program); Two years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Department of Health and Welfare

**Frequency of Verification:**

- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  *Check each that applies:*

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Targeted Case Management Provider conducts care management activities for traditional waiver participants. For participants who family-direct, case management is included in the support broker services.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) All waiver providers that provide direct care or services to participant must satisfactorily complete a criminal history and background check (completed by the Criminal History Unit of DHW) in accordance with Idaho Administrative Code at IDAPA 16.05.06, “Criminal History and Background Checks.” Criminal History Checks review information obtained from the Federal Bureau of Investigation, the National Criminal History Background Check System, the Idaho State Police Bureau of Criminal Identification, the statewide Child Abuse Registry, the Adult Protection Registry, the Sexual Offender Registry, and the Medicaid Surveillance and Utilization Review exclusion list.

Traditional waiver providers sign a written agreement to comply with all rules and regulations relevant to the services they provide. This includes compliance with IDAPA 16.05.06. Criminal history background checks are also reviewed during retrospective quality assurance surveys conducted by the Department.

Participants and families who choose to family-direct may waive this requirement for community support workers. In this case, the waiver of this requirement must be in writing and must be maintained by the

Fiscal/Employer Agent. The waiver must be signed by the participant and the parent/legal guardian and must state; 1) why the participant is waiving the criminal history check, 2) how the participant will assure health & safety without obtaining the criminal history check, and 3) that the participant understands the risk with waiving the criminal history check and accepts this increased risk.

Additionally, for family-directed participants, the Department will monitor criminal history check waivers in the following ways:

- Participant outcome interviews will include a sampling of participants who have waived the criminal history check for a community support worker.

- The Department will receive a list of criminal history check waivers from the Fiscal/Employer Agent.

- The Department will conduct a search of the complaint/incident database for any complaints or incidents associated with the participants and community support workers who have a criminal history check waiver.

- Quality Oversight Reports to the Quality Oversight Committee will include an analysis of the impact of this waiver process.

For family-direction, prior to providing reimbursable services to the participant, the support broker and community support workers must submit a copy of the clearance letter received from the Department's Criminal History Check Unit or a copy of the completed criminal history background check waiver, as applicable.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The Idaho Department of Health & Welfare – Division of Family & Children's Services is responsible for maintaining the Child Abuse Registry. The Adult Protection Registry is maintained by Idaho Commission on Aging.

(b) Criminal history checks include review of the abuse registries and criminal history checks are completed by the IDHW Criminal History Unit. The positions that require abuse registry screening are the same as positions requiring criminal history checks.

(c) The Idaho Department of Health and Welfare-Division of Family and Community Services maintains the Child Abuse Registry, and the Adult Commission on Aging maintains the Adult Abuse Registry. The Idaho Department of Health and Welfare- Criminal History Unit completes the criminal history check process, and the criminal history check process includes review of the registry.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon**

**request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

Respite is the only waiver service that may be provided by relatives of a participant. A parent or legal guardian cannot furnish waiver services, but a relative may be paid to provide respite services whenever the relative is qualified to provide respite as specified in Appendix C-1/C-3. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, family-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and approval of Action Plans and retrospective quality assurance reviews.

All providers are precluded from being in a position to both influence a participant's decision making and benefit financially from these decisions. Payments for family-directed services rendered are made only after review and approval by the participant and review by the Fiscal Employer Agent. Additionally, the participant's Support Broker and Circle of Supports are available to address any conflicts of interest.

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Lists of current providers are available from the IAP and regional offices. Provider qualifications and requirements are published in the Department's Administrative Rules and are available online at http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm. Specific Medicaid provider information, including provider handbooks and provider enrollment information, is available on the Department of Health and Welfare website at www.healthandwelfare.idaho.gov by clicking on the "Providers" button, then "Medicaid Providers" link.

# Appendix C: Participant Services

## Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of DD service providers, by provider type, who require licensure or certification and have a current license or certificate at the time they provide Medicaid services to DD participants.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance*

*measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of non-licensed, non-certified DD service providers, by provider type, who demonstrate compliance within minimum provider requirements.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| | |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of DD direct care staff that meet state requirements for training.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: Biennial | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Biennial |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Department ensures positive participant outcomes and quality of care through participant outcome reviews and data analysis. Through these two data collection processes, individual problems are discovered and remediated.

Participant outcome reviews involve the utilization of the Participant Experience Survey (PES). The first two steps include collecting demographic and medical/social history from the participant's file and administering the PES by surveying the participant and family in person. If areas of concern are identified during this initial review, an enhanced review is conducted for further investigation. This involves interviews with the participant, close family or friends, and the service provider.

If a service deficiency is found during an Enhanced review, a Plan of Correction (POC) is initiated. The POC must include a response to each deficiency stating:

- What actions will be taken,
- Who will be responsible for the corrective action,
- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

If the review reveals issues that potentially put the participant's health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

System Data Review involves obtaining data for indicators not specific to the participant outcome review, including provider requirements and contract monitoring. The data for these indicators are collected through quarterly, annual, biennial reports and reviews.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

a) All waiver services are included in the budget.

(b) The service and support desires and needs of participants measured by the Scales of Independent Behavior Revised (SIB-R), historical record of service expenditures, when available, and the characteristics of persons served measured by the Idaho Individual Budget Screen are used in a stepwise regression analysis to develop a prospective individual budget for each waiver participant. The budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. Maximum dollar amounts will be based on individual assessed needs and aggregate cost-effectiveness levels. This budget-setting is completed by the Independent Assessment Providers (IAP) in advance of the family-centered planning process and is used in the development of an Action Plan.

(c) The individualized budget is based on the perspective that funding should be tied principally to individual need. The model seeks out the factors that contribute the most to explaining observed variance in costs and discards those that do not appear to influence cost. A review will be done on an annual basis to evaluate the current variables to determine if they continue to contribute to the cost of individuals. In the end, the model identifies the mix and weight of variables that best fits the array of observed costs across the individuals receiving services. Ongoing monitoring of the statistical model, complaints, appeals, and participant outcomes will be conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety of participants in the community. When the Department determines that a change needs to be made to the individualized budget methodology, participants will be sent notification of the change prior to implementation.

(d) Participants who believe that their assigned budget does not accurately reflect their needs may appeal the decision and request a fair hearing.

(e) The Department has processes in place for participants to be re-evaluated and have a new budget assigned when the participant has a change in condition that requires additional services or higher cost services. Participants may request a re-evaluation by submitting documentation of changes to individualized needs to the TCM. If the documentation supports the need for additional budget funds, the TCM forwards the request to the IAP for a new individualized budget evaluation. If the documentation does not support the need for additional budget funds, the TCM provides written notification to the participant of the decision and the right to appeal.

(f) Participants are notified of their eligibility for waiver services and given an annual individual budget at the time of their initial determination or annual re-determination. Each participant receives written notification of the set budget amount. The notification includes how the participant may appeal the set budget amount decision. Individualized budgets are re-evaluated annually by the IAP and written notification of the set budget amount are sent annually.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The State employs another type of limit.
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**
Action Plan

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
*Specify qualifications:*

☐ **Social Worker.**
*Specify qualifications:*

☑ **Other**
*Specify the individuals and their qualifications:*

The responsibility for service plan development and qualifications differ slightly based on the participant's selection of either traditional waiver services or family-directed waiver services.

Traditional Waiver Services:
The Targeted Case Manager (TCM) will be responsible for developing the Action Plan in coordination with the participant and their family. Neither a provider of direct services to the participant nor the assessor may be chosen to develop the Action Plan.

TCM Qualifications:
Targeted Case Manager I - Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and have 24 months supervised experience working with children with disabilities.

Targeted Case Manager II - Minimum of a Master's Degree in a human services field from a nationally accredited university or college and have 12 months supervised experience working with children with disabilities.

Family-Directed Waiver Services:
Under the family-directed model, a qualified parent is permitted to act as an unpaid support broker, or the family may choose to hire an approved support broker to purchase specific duties as needed.
The paid support broker may assist the family in developing and maintaining a support and spending plan. The plan must include the supports that the participant needs and wants, related risks identified with the participant's needs and preferences, and a comprehensive risk plan for each potential risk. This plan must be reviewed and prior authorized by the Department prior to implementation.
Specific qualifications are outlined in Idaho Administrative Code - IDAPA 16.03.13. It includes review of education, experience, successful completion of Support Broker training and ongoing education.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) In both the traditional and family-directed options, the plan is developed by the participant and family with their support team. The support team is typically comprised of the plan developer or a support broker, the parent/legal guardian, at least one involved care giver and any friends, family or support staff that the family wants to invite. The number of people who can be involved is not limited. Besides the participant and the parent/legal guardian, the plan developer is the only person who is required to be a member of the support team.

In the traditional model, the plan developer submits the Action Plan to the Department's care manager at least 45 days prior to the expiration date of the current Action Plan. This requirement is stated in IDAPA 16.03.10. The Department has 45 days to review the Action Plan, discuss any issues with the plan developer, request changes as needed, and enter the authorization into the MMIS.

Participants and families who choose to family-direct their services submit their Support and Spending Plan directly to the Department's care manager for review and authorization. The care manager has ten (10) days to review the plan. The participant and family, and their circle of supports are in charge of how long the plan development process takes. The process may take from a few days to much longer, depending on the needs and wants of the participant, their family and the support team.

(b) The IAP conducts and or collects a variety of assessments at the time of initial application and on an annual basis, as noted, for both the traditional waiver services and the family-directed option.

The IAP conducts the following assessments at the time of the initial application for DD waiver services:
• Scales of Independent Behavior – Revised (SIB-R) functional assessment.
• Medical, Social and Developmental Assessment Summary.

At the time of annual re-determination, the IAP conducts and/or reviews the following:
• The Medical, Social and Developmental Assessment Summary is reviewed and updated.
• The SIB-R results are reviewed and another assessment performed if there are significant changes in the participant’s situation or the reassessment criteria are met.

The following assessments are gathered on an as-needed basis or may be used as historical information at the time of both initial and annual re-determinations:
• Psychological evaluations, including evaluations regarding cognitive abilities, mental health issues and issues related to traumatic brain injury.
• Neuropsychological evaluations.
• Physical, occupational and speech-language pathology evaluations.
• Developmental and specific skill assessments.

The results of a physical examination by the participant’s primary care physician are provided to the IAP on an annual basis. The physician can provide information using the Medical Care Evaluation Form and/or by submitting a narrative report.

Participants using traditional waiver services, and their support team, must complete a Health and Well Being Checklist which assesses and documents health and safety issues. Participants using the family-directed option, and their support team, must complete safety plans related to any identified health and safety risks and submit them to the care manager.

In the traditional waiver option, the participant and family's needs, goals, preferences and health status are summarized on the Action Plan. This document is a result of the family-centered planning meeting listing a review of all assessed needs and participant and family preferences. In addition, the plan developer is responsible to collect data status reviews from all paid providers, synthesize all of the information and include it on the Action Plan. The participant's parent/legal guardian sign the Action Plan to indicate it is correct, complete, and represents the

participant and family's needs and wants.

Family-directed participant's needs, goals, preferences, health status, and safety risks are summarized on the Support and Spending Plan and in the Family-Direction Workbook. The circle of supports, using family-centered planning, develops these documents and submits them to the Department's care manager at the time of initial/annual plan review.

(c) Participants and families, along with other members of the support team can receive information regarding the waiver services through several methods:

• The Department of Health and Welfare web site for Children's DD Services will have a page giving a detailed explanation for each service provided under the waiver. This information will be posted on the website following federal and state approval, and is anticipated to be posted no later than the implementation date of July 1, 2011. The URL for the web site is: www.redesignforchildren.medicaid.idaho.gov.

• The IAP manual includes a list of all waiver services with a description of what each service entails. The IAP uses this page to explain the various options to initial applicants.

• The IAP provides each new applicant with a Consumer Tool Kit which includes a listing of agencies in the local area that provide developmental disabilities services for children.

• The plan developer is charged with verbally explaining the various programs and options to the participant and family during the family-centered planning process, under the traditional option.

• The support broker is charged with assisting the participant to assess what services meet their needs, under the family-direction option.

(d) Idaho requires that a family-centered planning process be utilized in plan development to ensure that participant goals, needs and preferences are reflected on the Action Plan or on the Support and Spending Plan.

Plan developers, which can include a paid or unpaid person, are trained in family-centered planning, and possess the education and experience needed to assist families in making decisions about their child’s course of treatment and Medicaid services. The child’s goals, needs, and resources are identified through a Comprehensive Review process that includes review of assessments and history of services, and family-centered planning.

Participants and families who choose to family-direct must attend training offered by the Department prior to submitting a Support and Spending Plan. Completion of this training is documented in the family-direction quality assurance database. The training covers participant and family responsibilities in family-direction and the process of developing a Support and Spending Plan. The family-directed option utilizes a workbook and a support broker to ensure that the participant’s individual goals, needs and preferences are thoroughly explored and prioritized during the plan development process.

(e) Children's DD waiver participants typically receive a variety of waiver services, State Plan services, and other supports to address their needs and wants. The family-centered planning team works to ensure that the Action Plan adequately reflects the necessary services. The Action Plan is a single plan that includes the goals, objectives and assessment results from all of a child’s services and supports in the child’s system of care. The Action Plan will demonstrate collaboration is taking place among providers and that objectives are directly related to the goals of the family.

Under the traditional option, the responsibility is placed on the plan developer, plan monitor or Targeted Case Manager, IAP, and Department care manager.

- The IAP is responsible to submit the assessment and individualized budget to the plan developer.
- The plan developer and monitor is responsible to:
  - Ensure that services are not duplicative, and are complimentary and appropriate
  - Work with the members of the family-centered planning team and providers to ensure that the service needs of the participant are reflected on the Action Plan
  - Act as the primary contact for the family and providers
  - Link the family to training and education to promote the family's ability to competently choose from existing benefits
  - Complete a comprehensive review of the child’s needs, interests, and goals
  - Assist the family to allocate funding from their child’s individualized budget

- Monitor the progress of the Action Plan
- Ensure that changes to the Action Plan are completed when needed
- Facilitate communication between the providers in a child's system of care

Under the family-directed option, the responsibility is placed on the participant and family to coordinate services with assistance from the Department's care manager and F/EA as required.

- The IAP is responsible to submit the assessment and individualized budget to the Department's care manager.
- The family and a support broker uses the Family-Direction Workbook and the family-centered planning process to identify the participant's needs and develop a Support and Spending Plan.
- The Department's care manager reviews the plan to ensure that all health and safety risks are covered.
- The Fiscal/Employer Agent (F/EA) ensures that duplication of payment does not occur.

(f) Each participant using traditional waiver services must select and use a plan monitor who will monitor the plan. The family-centered planning team must identify the frequency of monitoring but at a minimum it must occur at least annually. In addition, the plan must be monitored for continuing quality. Plan monitoring ensures that the Action Plan continues to address the participant's goals, needs and preferences by requiring:

- Contact with the family at least annually or as needed to identify the current status of the program and changes if needed. Changes may be made to the plan when a service is added or eliminated, when service objectives or goals are changed, when there is a change in provider, or when the child's level of needs change. The plan should be changed to ensure that the services continue to align with the child's individualized budget and that the family is up to date on the services their child is receiving.
- Contact with service providers to identify barriers to service provision.
- Discuss satisfaction regarding quality and quantity of services with the family.
- Review of provider status reports and complete a plan monitor summary after the six month review and for annual plan development.
- Report any suspicion or allegation of abuse, neglect or exploitation to the appropriate authorities.

Participants and families who family-direct their services may choose to assume the responsibility of plan monitoring themselves, utilize members of the circle of supports, or require a support broker to perform these duties. This decision is made in the circle of supports during the family-centered planning process and is reflected in the Family-Direction Workbook.

(g) Each participant is required to complete a new Action Plan annually. The IAP sends written notification 120 days prior to the expiration of the current plan. The notice requests that the family schedule a meeting with the IAP to begin the process of eligibility re-determination and annual budget determination. Families will work closely with the TCM and at any time can determine the need to add, decrease, or change services. Both plans and addendums will be reviewed by the Department care manager.

Participants who are family-directing their services are required to complete a new Support and Spending Plan annually. Families can request changes be made to their Support and Spending plan at any time during the plan year by completing a plan change form and submitting to the Department's care manager for review.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Family-Centered Planning and Action Plan Development:
Risk assessment is evaluated as part of the family-centered planning process. Team members identify risks as part of the discussion for the Action Plan or Support and Spending Plan. Emergency back-up for support, and plans to mitigate identified risks are identified on the Action Plan. Specific information is identified on the service plans developed by providers for traditional waiver services or on the back-up plans for participants who family-direct. To assist with identification of risks the Department uses a Health and Well Being Form. This form is required with the Action Plan. The form looks at medical issues, supervision needs, abuse risks, risks that result from behavior issues

with the participant, exploitation risks, and financial risks. Along with identification, the form also identifies how the risk is being mitigated.

Children's Crisis Continuum
In addition to the family-centered planning process and Action Plan development, there are also services available when a child is at risk of or is experiencing a crisis situation. The following services are a part of the crisis continuum for children:

Therapeutic Consultation, defined in Appendix C-1, provides advanced assessments and planning for children who are not demonstrating outcomes with current treatment and it is anticipated that a crisis event may occur without the consultation;

Crisis Intervention, defined in Appendix C-1, provides immediate remediation and 24 hour support for children experiencing crisis. Crisis intervention may be provided in the child's home or in a short term out of home placement.

A Crisis Network Team is a team of Department staff that is utilized to case manage a crisis situation and assist the family when their child's behaviors are escalating. When a participant is in crisis, the Crisis Network Team determines the level of service needed and monitors the intervention until the situation is resolved.

Provider Agencies
Provider agencies are responsible to provide for health and safety and quality assurance for the participants they serve. The rules and provider agreements for services support that they are responsible to provide for safe and effective services and have processes in place to assure quality.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Once participants are determined eligible for waiver services, they and their families are given an opportunity to participate in orientation training about developmental disability services in Idaho. During family orientation, participants and their families are provided with a list of all approved waiver providers in the state of Idaho, which is organized by geographic area. This provider list includes the website link for the children's DD website at www.redesignforchildren.medicaid.idaho.gov so that participants and families have access to the most current providers in their area and across the state. Both the orientation and the provider list include a statement that the family may choose any willing and available provider in the state. Families are also informed of how to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, participants are informed that who they select is their choice and they may change their choice of providers if they want. The Targeted Case Manager is utilized to assist families in selecting service providers at the family's request.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

All proposed Action Plans must be reviewed and approved by the Department's Care Manager. All proposed Support and Spending Plans must be reviewed and approved by the Department's Care Manager. Prior to this approval, no services may be provided or billed because the plan has not been authorized and the prior authorization has not been entered into the MMIS.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

*Specify:*

Targeted Case Managers

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The family and targeted case manager (TCM) are responsible for monitoring the plan and participant's health and welfare ongoing. The TCM monitors the plan at a frequency determined by the family-centered planning team, and as authorized on the Action Plan. The TCM must make direct, in-person contact with the participant at least annually, but plan monitoring may occur more frequently as needed. Plan monitoring includes:

- Review of the Action Plan with the participant and family to identify the current status of programs and changes if needed;
- Contact with service providers to identify barriers to service provision;
- Discussion on participant satisfaction regarding quality and quantity of services. For example, when the participant and family expresses interest in changing providers, the TCM will assist them in exploring other provider options available to the family.
- Review of provider status reviews and complete a plan monitor summary after the six month review and for annual plan development. The plan monitor summary assists the TCM with tracking services and identifying any discrepancies with the plan. At the six month and annual review, the TCM compiles results from providers as part of the monitoring process.
- Ensuring back-up plans are in place and implemented as necessary.
- When problems are identified, the TCM will follow the appropriate procedure for reporting complaints and critical incidents to the Department, including contacting the crisis network team when it is discovered that the participant and/or family are in a crisis situation.

- Ensuring that all services and supports listed on the Action Plan, including the non-waiver services are being accessed and that collaboration is taking place among all providers in the child's system of care.

Participants and families who choose to family-direct are responsible for monitoring services with the assistance of the circle of supports. Participants may also choose to employ a support broker to perform some or all of these monitoring activities. The participant and circle of supports determine the frequency and methods for monitoring. The Department reviews the proposed Support and Spending Plan. If this plan does not detail sufficient monitoring to protect the participant's health and safety, the Department's care manager asks for additional detail and appropriate changes to the proposed plan prior to authorization.

The Department also reviews and investigates critical incident reports and complaints and conducts ongoing quality assurance outcome reviews. A representative sample of all waiver participants is reviewed on an ongoing basis.

**b. Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of service plans reviewed that addressed participant's functional needs as identified by the assessment.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| *(check each that applies):* | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Source** (Select one):
**Operating agency performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>IAP contractor | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who reported they have access to the services and supports they need.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants reviewed who reported their comments, questions and ideas were solicited/encouraged during their family centered planning meeting.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who had reported they know their targeted case manager.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |

☐ **Other**
Specify:

**Performance Measure:**
**Number and percent of participants reviewed who had reported their targeted case manager helps them get what they need.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |

| | |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percentage of participants reviewed who had reported satisfaction with their participation in activities within their communities.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| | |

| | |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who reported they made choices about their everyday life.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who reported they received support to learn something new in the past year.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed whose plan goal was acheived or modified in the past year.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/-5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of participants reviewed who had service plans approved prior to the expiration of the participant's current plan of service.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| *(check each that applies):* | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of modified plan addendum/update/modification requests reviewed and approved or denied within 15 days of receipt.**

**Data Source** (Select one):

**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of claims indicating utilization that is consistent with the service type, scope, amount, duration and frequency approved on service plans.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|

| *that applies):* | |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**e.** ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number and percent of waiver participants reviewed who had indicated they made a choice between waiver services and institutional care.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| | | |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who reported they were given a choice when selecting service providers.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Department ensures positive participant outcomes and quality of care through participant outcome reviews and data analysis. Through these two data collection processes, individual problems are discovered and remediated.
Participant outcome reviews involve the utilization of the Participant Experience Survey (PES). The first two steps include collecting demographic and medical/social history from the participant's file and administering the PES by surveying the participant and family in person. If areas of concern are identified during this initial review, an enhanced review is conducted for further investigation. This involves interviews with the participant, close family or friends, and the service provider.
If a service deficiency is found during an Enhanced review, a Plan of Correction (POC) is initiated. The POC must include a response to each deficiency stating:
- What actions will be taken,
- Who will be responsible for the corrective action,
- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

If the review reveals issues that potentially put the participant's health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

System Data Review involves obtaining data for indicators not specific to the participant outcome review, including provider requirements and contract monitoring. The data for these indicators are collected through quarterly, annual, biennial reports and reviews.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Idaho's family-direction option provides a more flexible system, enabling participants and families to exercise more choice and control over the services they receive which helps them live more productive and participatory lives within their home communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all waiver participants who choose to direct their own services and supports. The process supports participant and family preferences and honors their desire to family-direct their own services; how and when supports and services are provided; and who will assist them in developing and monitoring a realistic support and spending plan that accurately reflects their individual wants and needs.

Once participants are determined eligible for the waiver, an individualized budget is developed for each participant that incorporates an individualized budget methodology that is calculated consistently. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs. This allows for spending flexibility within the set budgeted dollars according to participant's needs and preferences. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of a participant's individual assessment, the individualized budget methodology which the Department uses to determine an individual's budget is reviewed with the participant and family either by an IAP representative or a Department staff.

Participants then have the option to choose Family-Directed Services (FDS). The FDS option allows eligible participants and families to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to provide those supports. Participants and families must use a support broker to assist them with the family-directed process. This can be accomplished in one of two ways: The family may choose to hire an approved support broker to perform specific duties as needed, or the family may choose to act as an unpaid support broker with the ability to perform the full range of support broker duties. If a parent/legal guardian wishes to act as an unpaid support broker for the participant, they must complete the support broker training and be approved by the Department. Paid support broker services are included as part of the community support services that participants may purchase out of their allotted budget dollars.

Support broker duties include planning, accessing, negotiating, and monitoring the family's chosen services to their

satisfaction. They can assist families to make informed choices, participate in a family-centered planning process, and become skilled at managing their own supports. The support broker possesses skills and knowledge that go beyond typical service coordination. The support broker assists participants to convene a circle of supports team and engages in a family-centered planning process. The circle of supports team assists participants in planning for and accessing needed services and supports based on their wants and needs within their established budget.

The FDS Option gives participants and families the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. Families and support brokers are responsible for the following:

- Accepting and honoring the guiding principles of family-direction to the best of their ability.

- Directing the family-centered planning process in order to identify and document support and service needs, wants, and preferences.

- Negotiating payment rates for all paid community supports they want to purchase.

- Developing and implementing employment/service agreements.

Families with the help of their support broker must develop a comprehensive support and spending plan based on the information gathered during the family-centered planning. The support and spending plan is reviewed and authorized by the Department and includes participant's preferences and interests by identifying all the supports and services, both paid and non-paid, and the participant's wants and needs to live successfully in their community.

Participants choose support services, categorized as "family-directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Personal Needs - focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life.

My Relationship Needs – identifies strategies in assisting an individual to establish and maintain relationships with immediate family members, friends, spouse, or other persons and build their natural support network.

My Emotional Needs – addresses strategies in assisting an individual to learn and increasingly practice behaviors consistent with the person's identified goals and wishes while minimizing interfering behaviors.

My Learning Needs - identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified.

Participants choosing the Family-Directed Services option in Idaho are required to choose a qualified financial management services provider to provide Financial Management Services (FMS). The FMS provider is utilized to process and make payments to community support workers for the community support services contained in their support and spending plan. FMS providers have primary responsibility for monitoring the dollars spent in accordance with the itemized spending plan and for ensuring payment itemization and accuracy. Financial management service providers also manage payroll expenses including required tax withholding, unemployment/workers compensation insurance; ensuring completion of criminal history checks and providing monthly reports to the participant, family, and support broker if applicable. Financial Management service providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of financial management service providers who are fiscal employer agents.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may

function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

- **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

- **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Department holds regular informational meetings where participants can learn about family-direction. Participants are also provided with informational materials during their initial and annual level of care

determinations by the Department. These materials include information about selecting either the traditional pathway or the family-directed pathway and include a self-assessment tool.

This self-assessment tool helps participants assess potential benefits, risks and responsibilities with selecting family-direction. Participants and families who express interest in family-direction will have a one-on-one orientation meeting with Department staff. At this meeting, families will receive a consumer toolkit that will guide them through the family-direction process of selecting a support broker or becoming a support broker, hiring community support workers, and utilizing Financial Management Services.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Participant-Directed Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Community Support Services | ☑ | ☑ |
| Support Broker Services | ☑ | ☑ |
| Financial Management Services | ☑ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

**Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- [ ] **Governmental entities**
- [x] **Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

**FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:**
**Financial Management Services**

**FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The Department enters into provider agreements with any qualified financial management service provider to provide Financial Management Services to participants who elect to family-direct. For HCBS waiver participants who choose the family-directed services (FDS)option, entities that furnish financial management services must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code as an FEA.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

One payment per member per month.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

*Specify:*

Establishing and maintaining an employment record for each paid community support that contains the employment application package, copies of licenses or certification as required, completed criminal history check or waiver, as applicable, time sheets, billing records, payment records, and required state and federal employment related documentation.

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

*Specify:*

Additional functions/activities:

- [x] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Department enters into provider agreements with qualified financial management service providers to perform financial management services for participants and families who choose to family-direct. Financial management service provider duties and responsibilities are outlined in IDAPA rule chapter 16.03.13. The Department monitors the activities of each financial management service provider through the following methods:

- Audits of transactions performed by each financial management service provider through selection of a random sample of participants and review of records and transactions that each financial management service provider has completed on behalf of those participants who have selected them as their provider. The audit methodology will use statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance.

- Requiring that each financial management service provider ensure the quality of the financial management services performed on behalf of all participants and review the results of these internal quality assurance activities.

- Assessment of participant satisfaction with the services provided by each financial management service provider as part of the participant experience survey.

- Formal assessment of each financial management service provider will occur at least every 3 years and on an as needed basis.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| Crisis Intervention | ☐ |
| Community Support Services | ☐ |
| Habilitative Supports | ☐ |
| Respite | ☐ |
| Habilitative Intervention | ☐ |
| Support Broker Services | ☑ |
| Financial Management Services | ☑ |
| Family/Interdisciplinary Training | ☐ |
| Therapeutic Consultation | ☐ |

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Department assists participants and families with this transition and assures that authorization for services under family-direction do not expire until new services are in place. The Department provides technical assistance and guidance as requested by participants, support brokers, and circles of support. Transition from family-direction to traditional services will not take more than 120 days and in most cases will be accomplished in 60 to 90 days. This transition time is spent re-determining the LOC needs, development of a new plan, and review and authorization of the new plan. The participant remains in family-direction until this process is completed so that there is no interruption in services. If at any time there are health and safety issues, the Department's care manager works closely with the participant to ensure that the participant's health and safety is protected. This may include utilizing the Crisis Network Team to address any immediate crises and/or authorizing an emergency 120-day transition plan to assure a smooth transition from family-directed waiver services to traditional waiver services.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Only demonstrated danger to the participant's health and safety would result in the termination of the participant's use of family-direction. In these cases, the Department will work closely with the participant, family, and support broker to identify necessary changes to the plan of service, authorize emergency services if necessary, and facilitate any other activities necessary to assure continuity of services during this transition.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 210 |
| **Year 2** | | 223 |
| **Year 3** | | 236 |

# Appendix E: Participant Direction of Services

## E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The identified community support worker will be responsible for paying for the criminal history background check.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☑ **Reallocate funds among services included in the budget**
- ☑ **Determine the amount paid for services within the State's established limits**
- ☑ **Substitute service providers**
- ☑ **Schedule the provision of services**
- ☑ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☑ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☑ **Identify service providers and refer for provider enrollment**
- ☑ **Authorize payment for waiver goods and services**
- ☑ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The service and support desires and needs of participants measured by the Scales of Independent Behavior Revised (SIB-R), historical record of service expenditures when available, and the characteristics of persons served measured by the Idaho Individual Budget Screen are used in a stepwise regression analysis to develop a prospective individual budget for each waiver participant. This budget-setting is completed in advance of the family-centered planning process and is used in the development of a family-centered plan. Participants and families using the family-directed pathway have the flexibility to choose providers and negotiate the rate of payment for their services. This flexibility allows them to make choices and prioritize needs in order to stay within an identified budget. Any participant has a right to an administrative hearing on decisions made by the

Department concerning the family-directed support. Participant outcomes will be monitored using Waiver Quality Indicators and visitations from state waiver staff members.

The individualized budget is based on the perspective that funding should be tied principally to individual need. The model seeks out the factors that contribute the most to explaining observed variance in costs and discards those that do not appear to influence cost. A review will be done on an annual basis to evaluate the current variables to determine if they continue to contribute to the cost of individuals. In the end, the model identifies the mix and weight of variables that best fits the array of observed costs across the individuals receiving services.

This budget setting methodology process is reviewed with each participant and family, during the initial and annual level of care assessment. It is documented publicly through the Administrative rulemaking process and published in the Idaho Administrative Code.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

An applicant who chooses the family-directed pathway will be notified of their eligibility for waiver services and given an annual individual budget at the time of their initial determination or annual re-determination. As outlined in Appendix C-4.a, participants who believe that their assigned budget does not accurately reflect their needs may appeal the assigned budget decision and request a fair hearing. The assigned budget is modified appropriately based on the outcome of the appeal process. If the participant is unable to develop a plan to meet their needs using the identified budget and family-direction processes, they will have the opportunity to choose a traditional pathway.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.** *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The participant and family's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the support and spending plan. They will send monthly statements to participants on a monthly basis to inform them on the status of expenditures. The support broker will assist the family to review these statements to assure spending is on track. Employment agreements are developed for each community support worker that are descriptive to what is expected and how they will be paid.

As part of the QA process, Medicaid staff monitor to assure that processes are in place to monitor these expenditures. Each fiscal agent is required to: 1) Have a system in place to perform a quarterly quality management (QM) analysis activity on a statistically significant sample of overall participant records; 2) Have documented, approved policies and procedures with stated timeframes for performing a quarterly quality management analysis activity on a statistically significant sample of overall participant records; 3) Have internal controls documented and in place for performing a quarterly QM analysis activity on a statistically significant sample of overall participant records; 4) Forward QM reports to the Department within thirty (30) working days from the end of each quarter. In addition to reviewing these quarterly reports, the Department also conducts a full service performance check on each fiscal agent provider at least every 3 years (all policies and procedures, and all the task and services as agreed upon in the provider agreement).

# Appendix F: Participant Rights

## Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are given the opportunity to appeal any Department decision that adversely affects their waiver eligibility or waiver services. Participants are sent a notice anytime an adverse action is made regarding their choice of HCBS vs. institutional services; their choice of provider or service; and for any denial, reduction, suspension, or termination of service. In addition, participants who do not meet ICF/MR Level of Care criteria for waiver eligibility receive an initial or annual notice stating they have been denied ICF/MR level of care. Department notices are provided to the participant and family in writing and contain information on appealing Department decisions that negatively affect eligibility or services. These notices include information that the participant may request to continue services during the appeal process. Copies of these notices are maintained in the participant file.

Participants and the public may learn more about the Department's fair hearing processes and policies by accessing the Department of Health & Welfare website at www.healthandwelfare.idaho.gov and clicking on the Idaho CareLine 2-1-1 link or by navigating to the Developmental Disabilities page. The Idaho CareLine website is also widely publicized in Idaho and can be accessed at www.idahocareline.org. When searching the database on the 211 Careline website, go to DHW – Fair Hearing. The CareLine provides a description of the Department's fair hearing process as well as contact information on where to go with additional questions. The fair hearing process will also be available on the children’s redesign website at www.redesignforchildren.medicaid.idaho.gov at the time of implementation, no later than July 1, 2011. The website will provide a list of answers to frequently asked questions including, "What if someone does not like the outcome of the assessment process?" In addition, the Consumer Toolkit distributed by the IAP, as well as the application for children's DD services describes the participant's right to appeal any Department decision that negatively affects their eligibility or services.

For participants electing to appeal, the fair hearing process is described in Idaho Department of Health and Welfare Rules,

IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." In the fair hearing process, a hearing officer acts as an impartial third party in reviewing Department actions. The Department and the participant each have the opportunity to present his/her case before the hearing officer. The hearing officer considers testimony and evidence presented during hearing along with the pertinent state rules and federal regulations in making a decision.

A written decision is issued by the hearing officer and is sent to the Department and to the participant. When all administrative remedies are exhausted, the participant may appeal the final decision by requesting a judicial review by the District Court.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Department of Health and Welfare

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When a complaint is received by the Department a determination will be made as to the severity of the complaint.

If the complainant alleges there is reasonable cause to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect, the complainant shall report or cause to be reported within twenty-four (24) hours such conditions or circumstances to the proper law enforcement agency or the department. (Idaho Statute 16-1605, Juvenile Proceedings, Child Protective Act).

Complaints or grievances which fall outside the following guidelines will be handled in this process:

•The issue must involve a potential for abuse, neglect, or exploitation of a participant OR
•Fraudulent use of a participant's Medicaid benefits AND
•Action must be taken by the staff person either to resolve the complaint or to refer the complaint outside the unit for resolution.

Complaints that do not rise to this level of severity, such as billing complaints or dissatisfaction with the provider agency will be handled in an informal matter. If the complaint is with the agency, the participant will be asked to contact them. If they are unable to do so, Department staff will intervene. Notes will be entered into the participant file or the provider file as appropriate. Billing issues will be referred to the MMIS representative in the region. They make notes on the MMIS system. Idaho's MMIS contractor uses a call escalation process to refer calls. They internally escalate displeased callers to the supervisor or manager and if the caller is still displeased, then the supervisor or manager refers the call to the Department's Medicaid Systems Support Team (MSST). If the call is regarding potential program abuse or possible fraud in a provider's billing, then the call is referred to the Department's Program Integrity Unit.

Timelines will vary with the nature of the complaint. If there is a complaint related to the health and safety of the participant, it will be handled immediately. Complaints that are not urgent, such as billing, will be handled within 30 days.

In addition, the Department conducts retrospective quality assurance reviews with a statistically valid sample of waiver participants (typically 10% to 20% of the waiver population). Participant satisfaction with services and service providers is assessed and tracked in these reviews.

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department requires that providers and other individuals responsible for monitoring the approved plan of service immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the child protection authority, or any other entity identified under Section 16-1605, Idaho Code, or federal law. Reports to the Department's care managers may be made by phone, mail, fax, email, or in person. The Department tracks reports received by the care manager through a Complaint/Incident Reporting Application.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of initial eligibility determination, all participants receive a "Consumer Toolkit." The toolkit contains

information on participant rights and contact information for the Department and advocacy organizations that they may contact if they have questions about their rights or want to file a complaint about a violation of rights. The Independent Assessment Provider (IAP) reviews the toolkit with the participant and other individuals who are accompanying the participant.

In addition, the targeted case manager provides education to the family during the annual family-centered planning process.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Professionals and other persons identified in Section 16-1605, Idaho Code, have a responsibility to report abuse, neglect, or abandonment and are provided protection for reporters. All Department of Health and Welfare personnel are responsible for recognizing and immediately reporting to Child and Family Services or to law enforcement any concern regarding abuse, neglect, or abandonment of a child or children. Failure to report as required by Section 16-1605, Idaho Code, is a misdemeanor. (IDAPA 16.06.01.551 Reporting Abuse Neglect, or Abandonment).

All other reports that come to the Department are followed-up on by the Department. All complaints or critical incidents are entered into the Complaint/Critical Incident Reporting Application. Reports that cannot be immediately resolved by the initial point of contact person are prioritized depending on the nature of the report.

When there is an immediate health or safety issue, a report must be followed-up on immediately and are typically reported to the child protection authority and/or law enforcement. When a report does not indicate that there is an immediate health or safety issue, the report must be acted on within ten business days. The Department ensures that staff adhere to these timelines. Review of statewide compliance with priority timelines is assessed at least quarterly during the Bureau Leadership Team meetings. The Bureau Leadership Team consists of the Bureau Chief and the Regional Program Managers.

Upon resolving the complaint, the assigned staff person or Unit will complete all documentation, notify appropriate agencies and participants, and notify the Department's DD Program Manager of the results and findings.
Additionally:
a. When corrective actions are required, the DD Program Manager will notify the Division of Medicaid Deputy Administrator, Regional Director, Facility Standards, Medicaid Program Integrity unit, and/or the Deputy Attorney General of investigation findings and recommended resolution.
b. The DD Program Manager may require that the investigating staff person or Unit expand the investigation or take additional action.
c. If Medicaid Fraud was substantiated, the DD Program Manager will notify Medicaid Program Integrity unit.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Health and Welfare is responsible for all other reports of critical incidents that affect waiver participants. The status and resolution of each report is available in the Complaint/Critical Incident Reporting Application.
All complaints and critical incidents are managed through a Complaint and Critical Incident database. On a monthly basis, a statewide team performs quality assurance reviews to insure that reports and investigations are timely and accurately documented. Also the team, on a quarterly basis, compiles and reports all children's DD related complaints and critical incidents to be analyzed.
Annually, all complaint and critical incidents are analyzed and trended and prepared in a report for the Division. On a bi-monthly basis, administration meets to review waiver and regionally based programs and activities, and dedicates part of its agenda to Quality Management. Each report details Quality Management related activities and reports Complaint and Critical Incidents and trends to the administration team.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

**a. Use of Restraints or Seclusion.** *(Select one)*:

**The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

**The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participant's rights regarding use of restraints or seclusion are provided under Sections 66-412 and 66-413, Idaho Code.
No restraints, other than physical restraint in an emergency, are allowed prior to the use of positive behavior interventions. The following restraints may be used under these circumstances:

Chemical Restraint: The use of any medication that results or is intended to result in the modification of behavior. Chemical restraint is only allowed when authorized by the attending physician.

Mechanical Restraint: Any device that the participant cannot remove easily that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body or environment. Excluded are devices used to achieve proper body position, balance, or alignment. Mechanical restraint may only be used when necessary for the safety of the participant or for the safety of others and only when authorized by the attending physician.

Physical Restraint: Any device or physical force that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition. Non-emergency physical restraint and seclusionary time out may be used only when a behavior implementation plan is developed. A seclusionary time out is the contingent removal of an individual from a setting in which reinforcement is occurring that is designed to result in a decrease in the rate, intensity, duration or probability of the occurrence of a response, and entails the removal of the individual to an isolated setting.

A behavior implementation plan must be developed by the participant, the parent/legal guardian, the family-centered planning team, and a therapeutic consultant or psychologist. Written informed consent is required for all use of restraints.

Personnel involved with administering restraints or seclusion must, at a minimum meet the provider qualifications of a habilitative interventionist as defined in Appendix C.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Health & Welfare is responsible for overseeing the use of restraints or seclusion.

The Department care managers review all plans of service prior to the implementation of the plan. When a provider believes the participant may require restraint and/or seclusion to be maintained safely in the community, the plan must outline how:

1) positive interventions will be used prior to restraint and/or seclusion
2) restraint and/or seclusion will be used
3) provide documentation that the appropriate authority (as outlined above) has reviewed and approved the use of restraints and/or seclusion.

The Department assures that these requirements have been met prior to approval and authorization of the plan. The plan of service is reviewed at least annually by the Department, or more frequently as necessary to monitor the services provided. When all of these assurances have not been met, the proposed plan of service is not authorized.

The Department also reviews all complaints received regarding inappropriate use of restraints/seclusion. If providers are discovered using restraint/seclusion without approval, they are referred to the appropriate authority (child protection, adult protection or law enforcement) and have appropriate action taken against their certification and provider agreement. Depending on the seriousness of the violation, action may be anything from a required plan of correction to termination of provider agreement.

The Department conducts outcome-based reviews on an annual basis. The Department samples a group of children accessing waiver services and performs both a file review and administers a participant experience survey (PES) in person with the parent or legal guardian and participant when appropriate. Through this process the Department discovers areas of concern and will escalate issues to the enhanced review process. Through this process, specific problems are identified and referred to the appropriate authorities for appropriate action to be taken. This action may be a required plan of correction, termination of the provider agreement or certification, or something in between depending on the seriousness of the violation.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**b. Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions may only be used when it is documented that they represent the least-restrictive environment for the participant to live safely and effectively in the community. In addition, positive behavior interventions must be used prior to and in conjunction with, the implementation of any restrictive intervention. All restrictive interventions must be included in the Action Plan and implementation plans and must be developed with involvement from the participant, the parent/legal guardian, the family-centered planning team, and a therapeutic consultant or psychologist.

When the program contains restrictive or aversive components, the therapeutic consultant or psychologist must review and approve, in writing, the plan prior to implementation. The TCM and parent or legal guardian must also be notified and agree to the restrictive intervention prior to implementation.

Personnel involved with administering restraints or seclusion must, at a minimum meet the provider qualifications of a habilitative interventionist as defined in Appendix C.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health & Welfare is responsible for monitoring and overseeing the use of restrictive interventions.

The Department reviews all plans of service prior to the implementation of the plan. When a provider believes the participant may require a restrictive intervention, the plan must detail how positive behavior interventions will be used prior to, and in conjunction with, the implementation of any restrictive intervention. In addition there must be documentation that the participant, the parent/legal guardian, the person-centered planning team and any other interested parties were involved in the decision-making process and agree that this represents the least-restrictive environment for the participant.

The Department assures that these requirements have been met prior to approval and authorization of the plan. When all of these assurances have not been met, the proposed plan of services is not authorized.

The Department also reviews all complaints received regarding violations of participant rights, including inappropriate use of restrictive interventions. If the care manager discovers a provider using restrictive interventions that are not approved on the Action Plan, appropriate action is taken. This action is typically a required plan of correction but may be more serious depending on the specific violation and the provider's history.

The Department conducts outcome-based reviews on an annual basis. The Department samples a group of children accessing waiver services and performs both a file review and administers a participant experience survey (PES) in person with the parent or legal guardian and participant when appropriate. Through this process the Department discovers areas of concern and will escalate issues to the enhanced review process. Through this process, specific problems are identified and referred to the appropriate authorities for appropriate action to be taken. This action may be a required plan of correction, termination of the provider agreement or certification, or something in between depending on the seriousness of the violation.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- ◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ○ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

# Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**i. Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  *Complete the following three items:*

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

# Appendix G: Participant Safeguards

## Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**
***The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**Number of participants reviewed that reported they know the person/place to go to report abuse.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** | |

| | | |
|---|---|---|
| | Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of critical incidents that are investigated consistently with priority guidelines.**

**Data Source** (Select one):
**Critical events and incident reports**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants who reported that their service providers were reliable.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of participants reviewed that reported they are free from abuse, neglect and exploitation.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who reported support staff treated them with respect.**

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample** Confidence Interval = =/- 5% |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants who have had an annual medical evaluation.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| | | =/- 5% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**Number and percent of participants reviewed who have had a dental exam once every six months.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative** |

| | | |
|---|---|---|
| | | **Sample** Confidence Interval = =/- 5% |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☑ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of direct service providers who have signed a self declaration form and have not disclosed any designated crimes prior to working with participants.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100%** |

| | | |
|---|---|---|
| | | **Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of critical incidents substantiated by type.**

**Data Source** (Select one):
**Critical events and incident reports**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid** | ☐ **Weekly** | ☑ **100% Review** |

| Agency | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number of substantiated complaints, by type.**

**Data Source** (Select one):
**Critical events and incident reports**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** | **Frequency of data collection/generation** | **Sampling Approach***(check each that applies):* |
|---|---|---|

| *(check each that applies):* | *(check each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Department ensures positive participant outcomes and quality of care through participant outcome reviews and data analysis. Through these two data collection processes, individual problems are discovered and remediated.

Participant outcome reviews involve the utilization of the Participant Experience Survey (PES). The first two steps include collecting demographic and medical/social history from the participant's file and administering the PES by surveying the participant and family in person. If areas of concern are identified during this initial review, an enhanced review is conducted for further investigation. This involves interviews with the participant, close family or friends, and the service provider.

If a service deficiency is found during an Enhanced review, a Plan of Correction (POC) is initiated. The POC must include a response to each deficiency stating:

- What actions will be taken,
- Who will be responsible for the corrective action,
- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

If the review reveals issues that potentially put the participant's health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

System Data Review involves obtaining data for indicators not specific to the participant outcome review, including provider requirements and contract monitoring. The data for these indicators are collected through quarterly, annual, biennial reports and reviews.

Regarding contractor performance, non-compliance will result in the contractor developing and submitting a plan of correction for Department approval. Continued non-compliance may result in termination of the contract.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the

Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Department has developed the following process for trending, prioritizing, and implementing system improvements that have been prompted as a result of data analysis:

1) The Quality Management Team is a group of Quality Assurance staff across seven regions of Idaho, who are responsible for collecting and reporting data to the central office Quality Management Data Analyst. QA staff are primarily responsible for gathering PES results, investigating complaint and critical incident reports, and reviewing Action Plans.

2) The Quality Management Data Analyst is identified as the specialist and lead for statewide data collection activities, analysis, and reporting activities related to quality management. This position is primarily responsible for creating and implementing data collection tools. Specifically, the QM Data Analyst reviews, analyzes and tabulates PES results, complaints and critical incidents, and Action Plan information.

3) The Department has established a Quality Management Committee responsible for steering the quality assessment and improvement process and issues related to parallel data collection. The QM Committee is primarily responsible for formally recommending specific program improvements to Department Administration. This committee meets annually upon completion of the annual QM report to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation is submitted to administration for approval and assignment.

4) The final component is the Quality Management Manager who is responsible for leading team members and the QM Committee, finalizing quarterly and yearly QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.

**ii. System Improvement Activities**

| **Responsible Party** *(check each that applies):* | **Frequency of Monitoring and Analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☑ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☑ **Quality Improvement Committee** | ☑ **Annually** |
| ☐ **Other** Specify: | ☐ **Other** Specify: |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Department has developed the following process for monitoring and analyzing the effectiveness of system design changes:

1)The Quality Management Team collects data and investigates complaints and incidents on an ongoing basis and submits this information to the QM Data Analyst for review.

2) The Data Analyst presents the data findings to the Quality Management Committee for review and prioritization.

3) The QM Committee meets on a quarterly basis to review the analyzed data in order to develop recommendations for program improvements, and review actions taken and progress made toward implementing previous approved system improvements. This quarterly progress is reported to administration.

4) The QM Committee submits the overall data findings and recommendations to the QM Manager for review prior to finalization.

There are several methods the Department uses to communicate policy changes and other important updates to the public. Information releases (IR) are issued to providers and/or participants to update them on policy, billing, or processing changes. IR's are often sent out to a specific group of providers or participants who may be directly impacted by any changes.

The Department also posts a MedicAide newsletter on the Department of Health and Welfare's website. The MedicAide newsletter is a monthly publication that communicates information to Medicaid providers and other interested parties, and incorporates any IR's that were issued the previous month.

In addition, state law requires that the public receive notification when a state agency initiates proposed rulemaking procedures and be given an opportunity to comment to that rulemaking. Notification of a proposed rulemaking is provided through a Legal Notice that publishes in local newspapers and the Department's website whenever a proposed rulemaking is being published in the Bulletin.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Department is consistently evaluating and improving processes and systems on an ongoing basis. Each year the Department improves services to waiver clients by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from differing groups.

An example is the Department's initiative to streamline quality improvement strategies across all Medicaid programs. The Department has identified the development of a global QIS strategy that could provide the following benefits:
• Performance Measures can apply to several Waivers
• Remediation can be tracked by Waiver and across multiple Waivers
• Data can be aggregated and analyzed across multiple Waivers
• Systems improvements can be developed to benefit all participants across multiple Waivers
• Effective and efficient way to monitor compliance with sub-assurances across multiple Waivers
• Strengthens oversight by an agency operating several Waivers
• Strengthens oversight of the Medicaid agency in concert with the operating agency

The Department identifies there is a need for a more coordinated approach to quality assurance in the Department and as a result has formed a quality assurance committee to develop a global quality improvement strategy and management plan, and develop a consistent complaint and critical incident collection and analysis process.

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon

request through the Medicaid agency or the operating agency (if applicable).

The Department must authorize all services reimbursed by Medicaid under the HCBS Waiver Program before the services are rendered. Prior authorizations for approved services are entered into the Medicaid Management Information System (MMIS) by the Department. The prior authorization number must appear on the claim or it will be denied. Approved prior authorizations are valid for one (1) year from the date of prior authorization by the Department unless otherwise indicated. Claims are adjudicated by the MMIS in accordance with Federal guidelines and Idaho policies. This includes extensive claim edit and audit processing, claim pricing, and claim suspense resolution processing.

The Surveillance and Utilization Review processes support the post-payment analysis of expenditures to identify potential misuse, abuse, quality of care, and treatment outcomes in Medicaid. Functions specifically supported by these processes include the traditional surveillance and utilization review (SUR) features of the MMIS, retrospective drug utilization review, and outcome-oriented analysis regarding quality of care assessments.

The Department conducts performance monitoring of the MMIS contract to ensure that claims are adjudicated by the MMIS in accordance with Federal guidelines and Idaho Policies.

All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

The State requires the MMIS contractor to contract with, and pay for an independent certified public accounting firm to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**In the aggregate the cost of services on the waiver does not exceed the average cost of ICF/MR services indicated in the most recently submitted 372 report.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Claims report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of demonstrated waiver service providers fraudulant billing patterns investigated by IDHW and action taken.**

**Data Source** (Select one):
**Critical events and incident reports**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**Number and percent of invoices paid by Fiscal/Employer Agent in excess of the amount approved for identified support categories on each participants support spending plans.**

**Data Source** (Select one):
**Provider performance monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Source** (Select one):
**Financial audits**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Department ensures positive participant outcomes and quality of care through participant outcome reviews and data analysis. Through these two data collection processes, individual problems are discovered and remediated.

Participant outcome reviews involves the utilization of the Participant Experience Survey (PES). The first two steps include collecting demographic and medical/social history from the participant's file and administering the PES by surveying the participant and family in person. If areas of concern are identified during this initial review, an enhanced review is conducted for further investigation. This involves interviews with the participant, close family or friends, and the service provider.

If a service deficiency is found during an Enhanced review, a Plan of Correction (POC) is initiated. The POC must include a response to each deficiency stating:

- What actions will be taken,

- Who will be responsible for the corrective action,
- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

If the review reveals issues that potentially put the participant's health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

System Data Review involves obtaining data for indicators not specific to the participant outcome review, including provider requirements and contract monitoring. The data for these indicators are collected through quarterly, annual, biennial reports and reviews.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Department implements procedures to comply with Idaho Code §56-118. This statute requires that the

Department implement methodology for annual review and determination of reimbursement rates to private businesses providing developmental disability agency services, mental health services, service coordination and case management services, residential habilitation agency services and affiliated residential habilitation specialized family services. A report of the results of this annual analysis is submitted annually, by November 30, to the Joint Finance-Appropriations Committee and the Health and Welfare Committee of the Senate and House of Representatives.

The annual analysis includes solicitation and survey of service providers for information and comment in order to establish rate determination methods and develop fair and equitable rates.

Pursuant to 42 CFR § 447.205, the Idaho Department of Health and Welfare gives notice of its proposed reimbursement changes by publishing legal notices throughout the State to inform providers about any change. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for participants to access.

Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. The Bureau of Financial Operations is responsible for rate determinations. The Department holds hearings when we promulgate rules to describe the reimbursement methodology.

Please see below for services and Reimbursement Methodology information:

Respite Individual Home/Community:
Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Respite Individual Home/Community Individual and Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 39-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using Global Insights Mountain States Market Basket (GI) inflation index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS Mountain West Division's (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Habilitative Supports:
Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Habilitative Supports Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 31-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Habilitative Intervention Individual Home/Community:
Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Habilitative Intervention Individual Home/Community Individual and Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Therapeutic Consultation:
Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Therapeutic Consultation Individual and Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 29-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Family /Staff Training Professional:
Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Family /Staff Training Professional Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Family /Staff Training Licensed:
Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Family /Staff Training Professional Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Crisis Intervention-Professional:
The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Crisis Intervention-Professional; we use the (BLS) mean wage (Idaho) for all others (BLS code 29-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Crisis Intervention Technician:
The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Crisis Intervention Technician we use the (BLS) mean wage (Idaho) for all others (BLS code 31-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Financial Management Services -Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. The established PMPM payment rates for each department approved qualified FMS provider will be published on a fee schedule by the Department. This fee schedule will be updated at least yearly, and when new providers are approved. This information will be published for consumer convenience to the IDHW Medicaid website, and by request.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Traditional DD waiver provider billing flows directly from the provider to the State's claim payment system, Idaho Medicaid's Management Information System (MMIS).

Participants who choose to family-direct their services and supports use a Fiscal Employer Agent to process provider billing. The Fiscal Employer Agent pays claims that have been approved on the plan and then bills the MMIS.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All Medicaid claims for waiver services are processed through the State's Medicaid Management Information System (MMIS). The MMIS is managed and monitored through the Department.

Participant eligibility is determined by the Division of Welfare. Once eligibility is determined, the participant's information and eligibility is electronically transmitted to the MMIS from the State's Idaho Benefits Eligibility System (IBES). Claims are edited against the eligibility file in the MMIS to ensure that claims are paid for Medicaid eligible participants only.

Prior authorization of Medicaid reimbursable services on the approved Action Plan is entered into the MMIS by the Department.

Explanation of Medicaid Benefits are generated monthly and sent to a sampling of participants receiving services to verify that the services were provided. The sample size of participants that receive an Explanation of Benefits notice is 1% of the eligible participants that had paid claims in the past months. The Department's Program Integrity Unit opens two to three cases per month based on participant responses to this auditing process. In addition, the Program Integrity Unit uses a utilization review system that categorizes all providers by type and specialty, ranks them in categories, and does a peer grouping analysis comparing provider billing patterns against their peers. It ranks the most probable abusive patterns from most to least abusive. Providers with probable abusive billing patterns receive further analysis by Program Integrity Unit staff and follow-up reviews are initiated when warranted. Finally, during retrospective quality assurance reviews, Department staff review participant progress notes and documentation of services. When staff discover inadequate documentation or inconsistent service delivery, they make a referral to the Program Integrity Unit for further investigation.

All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on

the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Family-Directed Services are paid through a qualified financial management service provider chosen by the participant. The financial management service provider then bills Medicaid through the MMIS as prior authorized by the Department. The financial management service provider chosen by the participant maintains records for each participant that indicate spending of the approved individualized budget within the following categories: 1) Support Broker Services; 2) Community Support Services, 2a) Job Support, 2b)Personal Support 2c) Relationship Support, 2d) Emotional Support, 2e) Learning Support, 2f) Transportation Support, 2g) Adaptive Equipment, and 2h) Skilled Nursing.

The Department enters into a provider agreement with qualified Financial Management Service providers to perform Financial Management Services for participants who choose to family-direct under the FDS option.

The Department monitors the financial activities of the qualified financial management service provider through quarterly financial audit and oversight activities through the following methods:

- Audits of transactions performed by the financial management service provider through selection of a random sample of participants and review of records and transactions that the financial management service provider has completed on behalf of those participants. The audit methodology will use statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance.

- Requiring that the financial management service providers ensure the quality of the services performed on behalf of all participants for who they provide Financial Management Services and reviewing the results of these internal quality assurance activities.

- Assessment of participant satisfaction with the services provided by qualified financial management service providers as part of the participant experience survey.

In addition to these quarterly financial oversight activities, the Department will issue an annual formal report and assessment of the financial audit findings to each FMS provider which will include the results of the combined quarterly financial assessments completed over the course of the year.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources

of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ( ) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The only waiver service that has the opportunity of being provided in a residential setting other than the personl home is respite care. Payments for respite are based solely on service costs and do not include the cost of room and board.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64: